Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON NORTHWEST MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEIL
6514 MCNEIL DR BLDG 2 SUITE 201
AUSTIN TX 78729

Respondent Name

ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-10-2318-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

December 28, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claimant…was injured on or about 12/01/2008 after sustaining an open right ankle fracture… The ankle was treated and repaired through open reduction and internal fixation on 12/1/08…the ankle became swollen and more and more painful… the patient presented to the ER due to concerns of infection and the pain in the ankle. It was warm and erythematous. He was thus admitted directly for further treatment and evaluation with a diagnosis of cellulitis and possible osteomyelitis. Cultures were collected and an antibiotic IV was started. Bone scan confirmed that the patient had osteomyelitis and Infectious Disease was consulted immediately, at which point the antibiotic treatment was changed. He developed loose stool and thus a work up was done to insure and rule out other infections. A PICC line was placed and once he was stabilized, the patient was discharged on 01/06/09 and placed on long-term antibiotics with further instructions." "… the Carrier has denied the claim as the services were not allegedly authorized. Regardless, the Hospital's records indicate that both the adjuster for the claim, Carlisle Araujo, and the case manager, Donna Somers, were notified of the admission and the underlying diagnosis. As the admission was on 12/31/09 (a Thursday), the Hospital could not obtain verification or authorization due to the holiday from 12/31/08 to 01/03/09. However, Ms. Summers was notified prior to discharge on or about 01/04/09 of the admission and course of treatment, the first business day after the admission. Likewise, the adjuster was notified of the admission and clinical review was provided to the carrier." "Undoubtedly, the admission met Interqual criteria under the infectious disease subset with the surgical wound infection over an implanted device and the IV antibiotics pending cultures."

Amount in Dispute: $39,560.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant was admitted o [sic] an emergency basis for an infection allegedly caused by an unsterile surgery theater that occurred on 12/01/08. Carrier denied reimbursement because of a lack of preauthorization based on insufficient documentation that emergency care was justified."

Response Submitted by: Flahive Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 31, 2008 To January 6, 2009	Inpatient Hospital Surgical Services	$39,560.96	$8,427.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.2, defines a medical emergency.
5. 28 Texas Administrative Code §180.22, sets out health care providers roles and responsibilities.
6. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
7. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 9, 2009
   - 197 –PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 930–PRE-AUTHORIZATION REQURIED, REIMBURSEMENT DENIED.

   Explanation of benefits dated April 2, 2009
   - 197 –PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 930–PRE-AUTHORIZATION REQURIED, REIMBURSEMENT DENIED.
   - W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 282–THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERING A BILL.
   - ***NO PRECERT OBTAINED

Issues

1. Did the services in dispute meet the criteria to sufficiently support a medical emergency in accordance with 28 Texas Administrative Code §133.2?
2. Was the injured employee's condition considered an "emergency" through the 5-day inpatient hospital stay?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The respondent denied the disputed services with denial reason codes: "197 – Payment denied/reduced for absence of precertification/authorization; and 930 – Pre-authorization required, reimbursement denied." 28 Texas Administrative Code §180.22(c) states, in pertinent part, that "The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care rendered to the employee…" 28 Texas Administrative Code §133.2(a)(4)(A) states that "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted documentation finds:

    - The emergency physician record states "context: fall."
    - The emergency physician record states "associated symptoms: snapping/popping sensation."
    - The emergency physician record states "clinical impression: cellulitis right ankle."
    - The medical records states "Chief Complaint – feet swelling; swelling right foot; reports pain in right foot. Admitting Diagnoses: 1. Status post open reduction and internal fixation, right ankle one month due to open ankle fracture in the right. 1. Cellulitis, right ankle. Physical Examination: On physical examination, positive finding are edema on the right distal leg and ankle. His skin temperature was warm to touch at the ankle and foot. Pulses are present. There is no crepitus or gross deformity seen. There is limited range of motion due to status post orthopedic surgery. There is mild blanchable erythema around the ankle joint in the lateral aspect. There is negative ascending erythema. Diagnostic Data: X-rays of the right ankle show hardware in place with no loosening of any of the plate or screws and there is no radiographic signs of osteomyelitis at this time. A triple phase bone scan 0335 bone can showed an increasing uptake on the right ankle with a diagnosis of osteomyelitis of the right ankle. Hospital Course: During the hospitalization, the patient received IV antibiotics. The patient improved of his cellulitis in the right ankle and also was evaluated by Infectious Diseases' doctor who considered putting the patient on a long term IV antibiotic treatment. On 01/05/09, the patient was placed on a PICC line for long term IV antibiotic. Discharge Medications: the patient will be receiving IV antibiotic per Infectious Disease."

    The requestor has supported the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of a body organ or part. The division finds that, having demonstrated a case of emergency, the requestor has met the exception to the requirement that the treating doctor shall approve or recommend all health care rendered to the employee. The Division concludes that the respondent's denial reasons are not supported. The disputed services will therefore be reviewed per applicable rules and fee guidelines.
2. Review of the submitted documentation finds the injured employee's admitting diagnoses was (1) status post open reduction and internal fixation, right ankle one month due to open ankle fracture in the right and (2) cellulitis, right ankle and the injured employee's discharge diagnoses was (1) status post open reduction and internal fixation, right ankle one month due to open ankle fracture on the right; (2) cellulitis, right ankle and (3) osteomyelitis, right ankle. Further review of the submitted documentation finds the in5-day inpatient hospital stay included: IV treatment with antibiotics and PICC line on January 5, 2009. The Division concludes that the injured employee's condition was considered an "emergency" through the 5-day inpatient hospital stay.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be: (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011." Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 863 is $5,893.13. This amount multiplied by 143% is $8,427.60.The total maximum allowable reimbursement (MAR) is therefore $8,427.60. The respondent previously paid $0.00, therefore an amount of $8,427.60 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $8,427.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $8,427.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 30, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	July 30, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.